



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JAMES WEISS, MD
3100 TIMMONS LANE
SUITE 250
HOUSTON, TX 77027

Carrier's Austin Representative Box
19

Respondent Name

Metropolitan Transit Authority

MFDR Date Received

March 28, 2011

MFDR Tracking Number

M4-11-2537-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated March 28, 2011: "Carrier refuses to pay. Full amount due for services rendered even after a request for reconsideration was submitted."

Amount in Dispute: \$735.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated April 13, 2011: "The carrier asserts that it has paid according to applicable fee guidelines."

Response required from: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
January 20, 2011	99204, 95861, 95900, 95903, 95904, A4556	\$735.54	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- Former 28 Texas Administrative Code, §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes filed prior to June 1, 2012
- 28 Texas Administrative Code §133.203 sets out medical bill submission requirements for health care providers
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1 – Workers Compensation State Fee Schedule Adjustment
 - (99204, 95903 4 units) 150 – Documentation does not support the medical necessity of 6 units of 95903. One study per extremity tested is allowed per LCD Electrodiagnostic Studies (NCS/EMG) – 4F-68AB-R7 for condition of Plexopathy, 2 units reimbursed.
 - (A5446) 97 – Supplies/electrodes are global of the reimbursement for the EMG/NCV.

- T13 – Medical necessity denial. You may submit a request for an IRO review no later than 45 days from receipt of this notice. Contact us for the IRO form.
- 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Are there any unresolved issues of medical necessity?
2. Are the services in dispute payable?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity for 99204 and 4 units of 95903 have been resolved prior to the filing of the request for medical fee dispute resolution. The requestor has failed to support 99204 and 4 units of 95903 are eligible for review pursuant to 28 Texas Administrative Code §133.307.
2. 28 Texas Administrative Code §134.20(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; ... and other payment policies in effect on the date a service is provided..." The medical bill for the service in dispute included HCPCS code A4556. Centers for Medicare & Medicaid Services (CMS) Change Request 2567, Transmittal B-03-020, Dated: FEBRUARY 28, 2003 states the following regarding the service in dispute; "A4556 - A4558 Electrodes; Lead Wires; Conductive Paste- Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier." Based on the medical documentation, this code was billed incident to a physicians' service. Therefore, no additional reimbursement can be recommended for A4556.
3. 28 Texas Administrative Code §134.203(c) is the applicable division fee schedule for calculation of the maximum allowable reimbursement for the services in dispute. For services in 2011, the maximum allowable reimbursement = (TDI-DWC Conversion Factor / Medicare CONV FACT) x Non-Facility Price or:

Code	MAR Calculation	Units	Allowable
99204	Not eligible for review	1	NA
95861	$(54.54 / 33.9764) \times 131.43$	1	\$210.00
95900	$(54.54 / 33.9764) \times (60.04 \times 6 \text{ units})$	6	\$578.27
95903	$(54.54 / 33.9764) \times (69.69 \times 2 \text{ units})$	2	\$223.73
95903	Not eligible for review	4	NA
95904	$(54.54 / 33.9764) \times (52.9 \times 6 \text{ units})$	6	\$509.50
A4556	Not separately payable	1	\$0.00
Total			\$1,521.50

The total allowable for the disputed services eligible for review is \$1,521.50. The carrier paid \$1,522.52. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	February 4, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812